Application for Medical Services

IHS Medical Facility

ASSIGNED CHART #

SECTION A	PATIENT DEMOGRAPHIC INFORMATION				
Patient Name:	[LAST]	[FIRST]	[MIDDLE INITIAL]	Patient Sex: [ ]MALE [ ]FEMALE	
Other Names Used:	Date of Birth:	Place of Birth:		Social Security#	
Address:	City:	State:	Zipcode:	Religion	
Community Name:	How long have you lived at this address?:	Is this on a Reservation?:		Marital Status: [ ]Single [ ]Married [ ]Widow [ ]Divorced [ ]Significant Other	
Home Phone#: ( )	Cell or Message Phone#: ( )	Which Reservation?			

SECTION B	PATIENT TRIBAL INFORMATION		
Are you: [ ] Enrolled Tribal Member [ ] Enrollment is Pending [ ] A decedent of an Enrolled Member	Tribe Name:	Agency enrolled at:	
	Enrollment/Census #:		

Father's Name:	[Last]	[First]	[Middle Initial]	Date of Birth:	Place of Birth:
Father's Tribal Affiliation?	Enrollment/Census#			Date of Death:	
Mother's Maiden Name:	[Last]	[First]	[Middle Initial]	Date of Birth:	Place of Birth
Mother's Tribal Affiliation?	Enrollment/Census#			Date of Death:	

SECTION C	EMPLOYMENT INFORMATION		
Are you employed: [ ] Yes [ ]No	If No, how long?	Do you receive: [ ]GA [ ]Other [ ]AFDC-Foodstamps [ ]Land Lease	
Employer Name:	How long with employer?	Employer Phone#	
Address:	City:	State:	Zipcode:
Are you a Student? [ ]Yes [ ]No [ ]Full-time [ ]Part-time	If yes, where?	How long?	Do you receive: [ ]Pell Grant [ ]Tribal Grant [ ]Scholarship [ ]Other

SECTION D	SPOUSE/SIGNIFICANT OTHER INFORMATION		
Spouse/Significant Other Name:	Date of Birth:	SSN:	
Is Spouse/Significant Other employed? [ ] Yes [ ] No	If No, how long?		
Employer Name:	How long have they been with this Employer?	Their Employer Phone#:	
Address:	City:	State:	Zipcode:
Is spouse/Significant Other a Student? [ ]Yes [ ]No [ ]Full-time [ ]Part-time	If yes, where?	How long?	Does Spouse/Significant Other receive: [ ]Pell Grant [ ]Tribal Grant [ ]Scholarship [ ]Other

SECTION E	MILITARY SERVICE		
Were you ever in any Military Service? [ ]Yes [ ]No	If YES, which Branch?	Claim#	Vietnam Veteran [ ]Yes [ ]No
	Entry Date:	Separation Date	Service Connected [ ]Yes [ ]No

I certify that the information provided on this form is true to the best of my knowledge.

Signature

Date

Application for Medical Services

SECTION F CONTACT INFORMATION

Person who can be contacted in the event of an emergency:

Name:	Relationship:		Phone#
Address:	City:	State:	Zipcode:

Next of Kin (Different from your Emergency Contact above)

Name:	Relationship:		Phone#
Address:	City:	State:	Zipcode:

SECTION G ALTERNATE RESOURCE INFORMATION

MEDICARE PROGRAM

Do you currently have Medicare? [ ]Yes [ ]No	Medicare Number:
Are you currently 65 years or older? [ ]Yes [ ]No	Are you disabled? [ ]Yes [ ]No

AHCCCS or Out-of State MEDICAID Program

Are you currently enrolled with the Arizona AHCCCS Program? [ ]Yes [ ]No	If yes, please give Health Plan Name: [ ]Indian Health Service (IHS) [ ]Phoenix Health Plan [ ]Mercy Care Plan [ ]Health Choice of AZ [ ]Maricopa Health Plan [ ]AHCCCS Select [ ]Cigna Community Health [ ]Arizona Physicians IPA [ ]Other_____
If you are not enrolled in the Arizona AHCCCS Program, are you enrolled in another state? [ ]Yes [ ]No State:_____	

PRIVATE INSURANCE

Are you covered under a Private Insurance Plan? [ ]Yes [ ]No	If yes, what is the name of your insurance?	
Who is the primary insured (policy holder)?	Their Social Security Number:	Date of Birth:

SECTION H TRIBAL VERIFICATION (If applicable)

The Indian Patient identified above is receiving or has requested medical treatment at this IHS Facility.
The Application for Medical Services Form has been completed and outlines facts relative to the patient status.
Verification of this patient as a beneficiary of the PHS Indian Health Service Program falling within the priority of service established for your Service Unit is requested. This can be done by completing the lower part of this form.
Your prompt reply will be appreciated.

Lori Aguilar, Chief, Patient Business Services
Phoenix Indian Medical Center

[Please complete one of the options below]

Option 1 Enrolled [ ] Check if applicable

I hereby certify that (above named)_____ with the date of birth of_____

is listed as a member of our tribe, with an enrollment/census number of _____, and is _____

(1/4, 1/2, 4/4) degree of _____ Indian Blood. [Signature Below]

Option 2 Descendent [ ] Check if applicable

I hereby certify that _____, parent of _____ as shown by

Birth Certificate, is listed on our rolls with the number _____ and is _____(1/4, 1/2, 4/4)

degree of _____(Tribe). [Signature Below]

Option 3 Not Eligible [ ] Check if applicable

Our agency does not show record of this applicant as being a member of ths Tribe/Agency, nor is there evidence showing descendency of this applicant. At this time, we ARE NOT acknowledging enrollment or descendency of this applicant.

[Signature Below]

Verification

I hereby certify that I am authorized by the _____ tribe to make the above enrollment determination and that the above is true and correct.

Date	Signature	Print Name & Title